Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

Snohomish County

Regence BlueShield
1800 Ninth Avenue
Seattle, WA 98101
Mail form to: PO Box 1271
Portland, OR 97207-1271
Fax to: 1-866-303-5117

Application For Enrollment/Change (for self-insured groups)

Please print in black ink. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." **The form must be signed and dated or it will be returned.** The five boxes directly below should be completed by the Group Administrator.

Health Group Number	Subgroup	Class	Group Name	Requested Effective Date
1 0 0 0 8 6 9 5	n/a	n/a	**Snohomish County**	(mm/dd/yyyy)

Employee Last Name	First Name	Middle Initial

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

NEW ENROLLMENT

New Enrollment due to:
☐ Open Enrollment ☐ New Hire ☐ Rehire-Date (mm/dd/yyyy)
☐ Satisfaction of non-time-lapse based eligibility criteria (mm/dd/yyyy)

Subscribers Current Employment Status:
☐ Actively working
☐ Retiree — Retirement Start Date (mm/dd/yyyy)
☐ COBRA Participant — COBRA Start Date (mm/dd/yyyy)
☐ Long Term Disability — Long Term Disability Start Date (mm/dd/yyyy)

CHANGE

Change:
☐ Add employee with/without dependent(s) ☐ Add dependent(s) only-Employee must already be enrolled ☐ Plan Selection

Change due to:
☐ Birth ☐ Marriage ☐ Adoption ☐ Open Enrollment ☐ COBRA Coverage Exhausted
☐ Loss of Eligibility on another plan ☐ Court Order
☐ Add Eligible Domestic Partner ☐ Loss of Medicaid or CHIP
☐ Eligibility for group premium assistance under Medicaid or CHIP
☐ Permanent change of place of residence, work, or living outside current plan's service area

Date of Change Event
(mm/dd/yyyy)

Demographic Information Change:
☐ Name Change ☐ Address Change

CANCELLATION AND/OR COBRA OR NON-COBRA CONTINUATION ENROLLMENT

Cancellation: (select cancellation reason and enter cancellation date below)
☐ Cancel Employee and All Dependent(s) ☐ Cancel All Dependent(s)
☐ Cancel Dependent(s) - List: _____

COBRA or Non-COBRA Continuation Enrollment:
☐ COBRA ☐ Non-COBRA Continuation

Cancellation Reason/COBRA or Non-COBRA Continuation Qualifying Event:
☐ Enrolled child no longer eligible ☐ Death ☐ Medicare Entitlement ☐ Military Leave
☐ Divorce, annulment, or termination of Domestic Partnership ☐ Reduction of Hours
☐ Termination of Employment ☐ Other Medical Coverage ☐ Other reason _____

Date of Cancellation Event
(mm/dd/yyyy)

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SECTION 2 - PLAN SELECTION

MEDICAL:
- ☐ **Select 17** - Cat. F & H
- ☐ **PPO 200** - Cat. F & H
- ☐ **Select 20** - Cat. D & G
- ☐ **None** - electing vision only
- ☐ **PPO 250** - Retirees only
- ☐ **Plan A** - Cat. A, B, C, E & I
- ☐ **Plan B** - Cat. A, B, C, E & I

VISION: ☐ Yes ☐ No

SECTION 3 - EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial
Mailing Address	City, State, and ZIP Code	
Physical Address	City, State, and ZIP Code	

Daytime Telephone Number (xxx) xxx-xxxx	E-mail Address Email address	Primary Language

Date of Birth (mm/dd/yyyy)	Gender: ☐ Female ☐ Male	Social Security Number	Original Date of Hire (mm/dd/yyyy)

Full-time Date of Hire (mm/dd/yyyy)	Hours Per Week	Marital Status: ☐ Single ☐ Divorced ☐ Married or Registered Domestic Partner ☐ Non-Registered Domestic Partner*

List your choice of Primary Care Doctor for yourself. Write name and address of your doctor (required) and medical group name (if known), below.

What type of member card would you like to receive?
☐ Family Level Card (all members listed on the same card) ☐ Member Level Card (each member on a separate card)

*** Non-Registered Domestic Partners must submit an Affidavit of Domestic Partnership.**

SECTION 4 - ENROLLING DEPENDENTS

Gender	Name(s) of Individual(s) to be Covered (First, Middle, Last)	Medical	Vision	Relationship to Applicant	Social Security Number for each Individual Covered	Birthdate Mo/Day/Yr
☐F ☐M		☐	☐			
List your choice of Primary Care Doctor for this dependent. Write name and address of your dependent's doctor (required) and medical group name (if known), below.						
☐F ☐M		☐	☐			
List your choice of Primary Care Doctor for this dependent. Write name and address of your dependent's doctor (required) and medical group name (if known), below.						
☐F ☐M		☐	☐			
List your choice of Primary Care Doctor for this dependent. Write name and address of your dependent's doctor (required) and medical group name (if known), below.						
☐F ☐M		☐	☐			
List your choice of Primary Care Doctor for this dependent. Write name and address of your dependent's doctor (required) and medical group name (if known), below.						

If you need extra space, please request an additional form from your group administrator.

Application For Enrollment/Change (continued)

SECTION 5 - CHILD CUSTODY INFORMATION

If natural parents are separated or divorced, please indicate below who has legal custody of the child(ren). Please use additional paper if needed. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the health care insurance of the dependent(s) so that the carrier can determine whose coverage is primary.

Name of Child(ren)	Father	Mother	Joint	Other	Date awarded	Who is required to provide coverage for the child(ren)?
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	

SECTION 6 - CURRENT AND PRIOR COVERAGE

Name of Covered Members: Self and Dependent(s)	Insurance Company (Name, Phone Number, and Policy Number)	Date of Coverage	Will coverage continue while on this Plan?	Product and Coverage Type
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Vision **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Vision **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Vision **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Vision **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Vision **Medicare:** ☐ PartA ☐ PartB ☐ PartD

Reason for Medicare Entitlement (if applicable): ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

SECTION 7 - CONSENT TO ELECTRONIC DISTRIBUTION

Regence BlueShield (Regence) is engaged in efforts to increase the use of technology and curb the use of paper. In support of those efforts, Regence has established a process under which communications to members can be posted to a secured account that a member establishes on Regence.com, with e-mail notice provided to a member-supplied e-mail account when a new communication is posted.

By my signature below and unless I have expressly rejected electronic distribution by marking the checkbox below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that:

- To access electronically distributed communications, I and each of my covered dependents will need to establish Regence.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems.
- Not all member communications are currently available electronically, but agree that my consent will apply to the following materials available, or as they become available, for electronic distribution, (i) notices of enrollment and/or effective date, (ii) acknowledgements of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgements of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements.
- Until a type of communication can be distributed electronically, a paper copy will be provided.
- Once available in electronic form, any electronically distributed communications may be printed from the Regence.com account where they are posted, or a paper copy of any particular communication may be requested at any time using Regence.com or by contacting Regence Customer Service at the number provided on my ID card.
- I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent (returning to paper distribution) at any time and without charge using Regence.com or by contacting Regence Customer Service as described in the previous bullet.

The e-mail address for receipt of notice of electronic distributions is Email address _____

☐ I do not want electronic distribution. Unless my consent is not required for an electronic distribution, I elect to receive communications related to this coverage in a paper format.

Applicant's Signature ▶ _____ Date (mm/dd/yyyy) _____

SECTION 8 - APPLICANT SIGNATURE

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the self-insured plan maintained by my employer (for which Regence provides claims administration services, but does not assume financial risk or obligation) and I agree to the terms and conditions of that plan. I agree to abide by the plan's enrollment provisions and certify that all those whom I seek to enroll, including myself, meet the plan's eligibility criteria. I understand that coverage cannot start until after I have served any eligibility waiting period included in the plan.

An eligible individual not listed on this application will be considered as waiving coverage. I acknowledge that I have had the opportunity to enroll, but do not wish to make application for any eligible individual not listed. In waiving coverage, I am aware that waiving individuals (including me, if I am waiving) may enroll later only at my group's anniversary, unless qualified for a Special Enrollment Period.

SECTION 8 - APPLICANT SIGNATURE (continued)

If I have waived enrollment for myself or any of my dependents (including my eligible spouse or domestic partner) because of other health insurance or group health plan coverage, I may in the future be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage or domestic partnership, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage or domestic partnership, or within 60 days after the birth, adoption, or placement if payment of additional premium is required to provide coverage for the dependent child. To obtain more information about these rules, please call 1 (800) 505-6801.

Except by express and duly authorized amendment to the plan, no person may change the terms of the plan. No person may waive the requirement that I answer all questions on this application completely and accurately.

I authorize my employer to act as my agent in all matters of administration of the group coverage, and acknowledge that my employer is in no way acting as agent for Regence. I agree to pay the appropriate premium rates for myself and my enrolling dependents in advance, and authorize payroll deduction of premiums as required.

I authorize any source to release to Regence, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Regence may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law. Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

I have provided these answers as part of the application procedure for the plan and I certify that all information completed on this form is true, correct, and complete. I understand that the plan will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform the plan in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Applicant's Signature ▶ _____ Date _____ (mm/dd/yyyy)